

the highest degree of efficiency in the profession? To enrich the members of the profession? No! Except as education enriches the mind and aids efficiency. The answer is, that the members may be better prepared and better qualified to give the best that medicine has to offer to every patient, rich or poor.

Why should organized medicine enlighten the public? To increase the prosperity of the doctor? No! The answer is, in order that the public may have such knowledge as to enable its members to know where to seek proper medical advice and to enable them to escape the pitfalls of quackery and charlatanism.

#### FORCES ANTAGONISTIC TO SCIENTIFIC MEDICINE

But while organized medicine is thus engaged it must remember that, immersed in their humanitarian interests, employing their time and talents in improving their efficiency, they are apt to forget that they are assailed by forces from without busily engaged in undermining the foundations of their organization. The members of the medical profession must be politically minded if they would not wish to see medicine dominated and regulated by political appointees, and its practitioners relegated to the limbo of forgotten men. Medicine must come out of the cloister, not only every two years at the time of elections or during the meetings of the legislature, but must come out and stay out. We must continue, as heretofore, to work for every measure intended to promote and protect public and individual health, and to continue to oppose every measure whose enactment would jeopardize that health, and continue to protect professional standards against the assaults of cultists and other such groups. We must be prepared to offer some constructive measures for the solution of the increased cost of sickness, and the uneven distribution of sickness. It is not enough to say we oppose this or that measure which we know is not to the best interests of the public, no matter how appealing such measures may be made to the untrained or the unthinking mind. The best defense is an offense. Foch, at the first battle of the Marne, with his right in confusion and his left retiring, attacked with his center and changed the course of the Great War. Let us attack with our center, with some constructive measure that will help spread the cost of sickness over a great number, so that the few who must meet with the financial strain of sickness may be protected by a common fund. And let the control of such a fund and the administration of such a system be under the control of medicine, where it belongs, or with the representatives of organized medicine rather than under the domination of a political body.

To do these and the many other things with which medicine, against its wishes and often to its dismay, must cope, will require a united profession and a full treasury. We will need the sinews of war. Will organized medicine present that united front and provide that treasury? These are two of the important issues organized

medicine must face. Upon the answers of organized medicine will largely depend its fate and the fate of the public which it endeavors to protect.

#### IN CONCLUSION

I cannot close this address without adding two comments. First, I wish to refute an impression which has been bruited in certain quarters and which has gone abroad in the land. I refer to the impression had by some, including those directing the policy of certain newspapers and magazines, that organized medicine in California is on the verge of revolt against its parent body, the American Medical Association. Medical men are trained thinkers and are, more or less, individualists. It is, therefore, not surprising that differences of opinion may arise, and have arisen, regarding the best methods for the solution of medical problems. Organized medicine in California is in close accord with the officers and members of the American Medical Association in their valiant efforts to uphold the standards of medicine and to prevent the exploitation of the profession and of the public. Any differences of opinion, such as have arisen, have been differences as to details and not as to fundamentals. These differences of opinion will be solved in a friendly coöperative spirit through evolution and not by revolution.

Second, I would repeat what I have said to every component county society: Read CALIFORNIA AND WESTERN MEDICINE. It is your medical journal and it is the outstanding state journal of this country. Read it; acquaint yourself with the problems of organized medicine and of the manner in which your officers are trying to solve those problems. The time has arrived when, if you are to survive, you must be not only a good doctor, but also an informed and active member of organized medicine.

Colfax School for the Tuberculous.

#### A RURAL CANCER CLINIC\*

By WILLIAM R. DORR, M.D.  
Arlington

DISCUSSION by Charles A. Dukes, M.D., Oakland; Alton R. Kilgore, M.D., San Francisco; Clarence G. Toland, M.D., Los Angeles.

INSTEAD of the above title, "A Rural Cancer Clinic," it might be more appropriate to head this article, the "First Annual Report of the Riverside County Cancer Study Group."

#### ORGANIZATION OF THE RIVERSIDE COUNTY GROUP

In the summer of 1934 a small group of the medical staff of the Riverside County Hospital met and discussed the feasibility of establishing a cancer clinic at the hospital, and decided to ask Dr. J. M. Flude, western representative of the American Society for the Control of Cancer, to advise the group. Doctor Flude came to a meeting at the hospital on August 27, and was accompanied by Dr. C. Hiram Weaver, chairman of the Cancer Clinic at the Hollywood Hospital, Hollywood.

\* From the Riverside County Hospital.

Nine local doctors attended this meeting and received a large amount of information and many helpful suggestions from these men. After this meeting several of the Riverside men visited the cancer clinics at the Los Angeles County Hospital and the Hollywood Hospital; literature was obtained from the American College of Surgeons and also from the Cancer Committee of the California Medical Association, and the first meeting of the Riverside County Cancer Study Group was held on October 3, 1934.

All of the doctors of the county were invited to attend this meeting, and twenty were present. Meetings have been held every week since the initial meeting, lasting one hour, from 12:30 to 1:30, and all members of the medical profession are welcome to attend and to participate in the examination and discussion of cases. Our attendance has averaged fourteen at each meeting for this first year.

#### DIVISION OF THE WORK

The meetings are divided into three sections: first, business session; second, study session; third, clinical session.

The business session at first consumed considerable time at each meeting, but soon was reduced to a minimum.

In instituting a study session, we frankly recognized that our "knowledge" of cancer might better be described as "ignorance," especially when it came to carrying out principles of treatment as recognized today. We have attempted to remedy this by studies made of different types of cancer by different members of the group, by talks, demonstrations and discussions by the pathologists, by reports and discussions on various articles read, and by all other means that have presented themselves to us.

The clinical session at each meeting is devoted to the study of new cases for diagnosis and recommendations relative to treatment; the presentation of old cases for further recommendations and to note the progress, and the presentation of specimens removed at operation or autopsy.

#### RELATION TO THE RIVERSIDE COUNTY HOSPITAL

All cases coming to the Riverside County Hospital or to the out-patient department that present any symptoms suspicious of cancer are automatically referred to the Group—in fact, we contemplate changing the name of the Group to the Riverside County Tumor Study Group, so as to be sure to see all suspicious cases.

At the start two handicaps presented themselves: First, there was no radium available for treatment, and patients had to be sent to Los Angeles, a distance of about fifty miles, for this treatment, and the prices charged soon demonstrated that the county would have to make other arrangements. The purchase of an adequate supply of radium, although undoubtedly the most economical in the long run, could not be financed, but we have made very satisfactory arrangements for radium treatments with a physician who comes to the hospital.

Second, there was no x-ray machine in the county capable of giving deep therapy treatments. Since then two machines have been installed by the two radiologists practicing in this district, and we have made satisfactory arrangements with one of them for the care of county cases needing such treatment.

#### CLINICAL MATERIAL DURING THE FIRST YEAR

During the first year of the Riverside County Cancer Study Group, 119 cases have been handled in the clinic, and of this number sixty-eight cases have been definitely proved to be malignant.

In trying to evaluate the work done during this first year, we cannot point to any scientific achievements that have been attained by the Group, either in diagnosis or treatment; nor at this time can we evaluate the benefits to the patients who have been treated, as the time under observation is too short to be of any conclusive value; nor can we attempt to summarize the benefits that have accrued to the different individual medical men who have attended the meetings, helped in the study of cases and entered into the discussions relative to diagnosis and treatment. The fact, however, that so many of the medical men have an almost 100 per cent attendance clearly demonstrates that they feel they are receiving real benefit from their association in the study of the cancer problem. At the end of another year we feel that we should begin to be able to point to more definite results.

#### OBJECTIVES TO BE SOUGHT

There are, however, three points that stand out in the first year's work: First, the fact that sixty-eight definitely proved malignant cases have been found in a single year in a county hospital serving a population of about 85,000 has been rather startling to many of the medical men of this community, and also to others who are interested in such matters. Second, the large percentage of far-advanced cases coming to the clinic, for which there is nothing that can be done except palliative measures. Third, the fact that several cases have been seen in which the primary treatment instituted was not an adequate treatment, so that the possibility of ultimate cure was lost.

The objectives of the Group up to the present time have been three in number:

1. To increase the knowledge of the individual members of the Group relative to the diagnosis and treatment of cancer.
2. To diagnose and cure as many cases of cancer as possible among the patients applying to the county for care.
3. To alleviate the suffering of the hopeless cases coming under the care of the hospital.

In considering the above objectives, the question naturally arises as to whether at this time we should attempt to broaden the field of our work and add to our objectives by instituting a campaign to reach a larger percentage of the population. We feel, therefore, that at this time we might with profit consider the advisability of instituting a program to educate the public of the county relative to the diagnosis and treatment of cancer, and the value of early recognition and

application of appropriate treatment. How might this be accomplished? Can we learn anything by studying the methods that have been used in controlling the different infectious diseases that formerly were so prevalent, but which now are practically under control?

The knowledge of how to control smallpox, diphtheria, typhoid fever, tetanus, yellow fever, typhus fever, and rabies, is now so accurate and exact that the control of these diseases has today become entirely the function of the organized public health service of the country, and has been definitely accepted as a function of government to be paid for from tax funds.

The magnitude of the problem involved in the control of tuberculosis has delayed the assumption of this burden by the taxpayers, but in recent years the results obtained by proper handling of cases have become so definite and encouraging that less and less is being done by private agencies and lay organizations with funds furnished by private individuals. Now a very large percentage of the curative work in tuberculosis is furnished in tax-supported institutions, and also the work of case finding and diagnosis is recognized as a public health problem and most of it is tax-supported. Research in tuberculosis control is, however, in the United States still a function or private enterprise, and is not to any appreciable extent assumed by the government. Many European governments, on the other hand, are spending large sums of money on this phase of the work.

#### IN CONCLUSION

It would appear at this time that our position in the control of malignancy is in the same position that the control of tuberculosis was some twenty-five years ago. We have a glimmering of the underlying principles that must be adopted to control this disease, but how to get these principles universally in use so that definite results may be obtained, is at this time decidedly obscure. It would appear that at this time the help of the general public must be obtained, and that the methods that have been used in furthering the control of tuberculosis are applicable to the control of cancer.

In closing, may we quote a statement with which we are in full accord, made in a recent *Bulletin of the American Society for the Control of Cancer*:

"Having built up a foundation of scientific and medical knowledge concerning the disease itself and the facilities for its treatment, the next step is clear. This consists in the establishment of local organizations which will assume the responsibility and expense of educating the laity to recognize signs and symptoms which may mean cancer and to report these signs and symptoms immediately for diagnosis and treatment."

Riverside County Hospital.

#### DISCUSSION

CHARLES A. DUKES, M. D. (426 Seventeenth Street, Oakland).—I approve of Doctor Dorr's paper and in his effort to organize a cancer clinic. It can be done when men like Doctor Dorr take the responsibility, and make the sacrifice of time and money to carry on.

The problem is a group one, and the general men can well care for many of the problems presented. Unless there can be as a part of the group a competent pathologist and radiologist, the clinic will not be complete. I am

convinced that all radiation should have the guiding hand of a well-trained physicist, as well as thorough clinical knowledge.

The average number of cancer cases in the indigent sick is about the same as we have found in Alameda County.

Publicity should be promoted through the Cancer Commission of the California Medical Association, and they at all times are ready to assist in this work.

The American College of Surgeons is approving the establishment of cancer clinics in all large centers, both of diagnostic and treatment types.

The solution of the problem of tuberculosis did not progress satisfactorily until the term "consumption" was dropped, and tuberculosis was used and understood by the layman. Is not the cancer problem analogous, and will not the great horror be lessened when we use "cancer clinic" and not try to subterfuge?

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ALSON R. KILGORE, M. D. (490 Post Street, San Francisco).—Doctor Dorr and the Riverside County Cancer Study Group are too modest in estimating their accomplishments. Results of their year's work are perfectly clear: The size of the local cancer problem has been demonstrated; treatment facilities have been provided that did not exist before, and the group of doctors are educating themselves in cancer diagnosis and treatment in a practical and effective way. An excellent example are the train of results which inevitably flow from the group method of cancer attack.

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CLARENCE G. TOLAND, M. D. (1930 Wilshire Boulevard, Los Angeles).—Cancer institutes and cancer clinics have existed for some years in the urban centers, but their influence has not appreciably penetrated beyond the metropolitan areas. The more recently organized cancer-study groups in the rural districts have contributed greatly to bridging this gap.

The Riverside County group, and in fact all rural groups, certainly function under material handicaps; and great credit is due these men who tolerate inconvenience and, in spite of inadequate equipment, persist in maintaining an efficient effective organization for cancer control.

Group opinion in cases with malignancy is obviously of great immediate value to the unfortunates who present themselves for examination. Unquestionably, they receive diagnostic service and advice concerning therapy superior to that rendered by their individual doctor. This fact alone more than justifies the existence of the cancer clinics, and makes the efforts of the group members worth while. It is this concern for his own welfare that directs the patient to the group. It is doubtful if his interest extends beyond to the broader, more important, greater educational benefits that are rendered by these groups to their community, and to cancer patients as a whole.

Progress in the campaign effectively to reduce the mortality and suffering from cancer is materially stimulated by the presence of cancer clinics in the smaller communities. The members of these groups are to be highly commended for the enthusiasm and coöperative spirit displayed in these centers. May the success of the Riverside County Cancer Clinic encourage the establishment of cancer-control organizations in other less fortunate rural districts!

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DR. DORR (Closing).—It may be of interest to append here a summary of work of the Riverside County Study Group:

#### Summary of Work

Riverside County Cancer Study Group for Year Ending September 30, 1935

Total cases examined .....	119
Diagnosed nonmalignant .....	52
Diagnosed malignant .....	67
By biopsy .....	44
Clinically .....	23
Classification:	
Sarcoma .....	5
Carcinoma .....	59
All others .....	3
Total .....	67

**Locations:**

Skin—Face .....	20
Extremities .....	6
Mouth .....	3
Pelvis .....	12
Abdomen—Gastro-Intestinal Tract .....	4
Liver .....	1
Rectum .....	1
Prostate .....	2
Chest—Lung .....	4
Breast .....	10
Bones .....	4
Total .....	67

**Treatments:**

Surgery .....	10
Cautery .....	20
X-ray .....	9
Radium .....	3
Palliative .....	22
None .....	11
Total .....	75

**Miscellaneous Statistics:**

Oldest patient .....	80 yrs.
Youngest patient .....	14 yrs.
Average age .....	56.6 yrs.
Number of deaths .....	16
Number with metastases .....	17

**ACUTE PERFORATION OF PEPTIC ULCER\*****AN EVALUATION OF DIAGNOSTIC SYMPTOMS  
AND SIGNS**

By HAROLD LINCOLN THOMPSON, M.D.  
Los Angeles

DISCUSSION by Wayland A. Morrison, M. D., Los Angeles; Edmund Butler, M. D., San Francisco; E. Eric Larson, M. D., Los Angeles.

THE typical case of acute perforation of peptic ulcer, which is seen early in its course and is complete with a history of previous dyspepsia, characteristic symptoms and classical physical signs, does not present an extremely difficult diagnostic problem. In fact, the diagnosis in typical cases is so easy that a mistake is usually the result of inexperience, haste or oversight on the part of the physician. Despite the ease with which the diagnosis may be made in typical cases, there is a varying proportion of cases which in one or more respects are atypical, and in these the establishment of a working diagnosis is exceedingly difficult. Published figures on the diagnostic error in acute perforation of peptic ulcer indicate that, on the whole, diagnosis is improving with experience in this condition. For example, the error in diagnosis in the series collected by Moynihan<sup>1</sup> in 1901 was as high as 36.7 per cent, whereas in the group published by Poole and Dineen<sup>2</sup> in 1922 it was only 11.8 per cent. Accumulated experience, moreover, has enabled us to classify the cases of acute perforation of peptic ulcer on the basis of clinical course into several fairly easily recognized groups. The largest group is comprised of the so-called typical cases. There does not appear to be any definite knowledge, however, concerning the size of this group or a consensus of opinion on how large a proportion of cases compose the atypical group. In view of the difficulty in diagnosis in a proportion of cases which generally is

acknowledged to be considerable, this clinical study was undertaken in an effort to determine the relative values of the several subjective symptoms and physical signs which are diagnostic of acute perforation of peptic ulcer.

**CLINICAL MATERIAL FOR THIS STUDY**

This study was made from the clinical records of five hundred cases of peptic ulcer, complicated by perforation, in which the clinical features were of the acute form. The important clinical features have been evaluated and interpreted in terms of the percentage of cases in which each feature was present. The analysis discloses that the atypical cases vary not only with respect to clinical course, but also with respect to important diagnostic symptoms and signs. That is to say, in addition to the groups which are recognized on the basis of clinical course, there is a remaining group consisting of cases which, in one or more particulars, do not conform to any group now recognized, and in which, therefore, the diagnosis is especially difficult.

**SO-CALLED CLASSICAL CASE OF ACUTE  
PERFORATION**

In the so-called classical case of acute perforation of peptic ulcer the history reveals that for some time the patient has been more or less disabled by a characteristic type of recurring dyspepsia. Then suddenly and unexpectedly he is stricken with epigastric pain so severe that it seems beyond endurance. On examination, soon after the onset of pain, the patient's face is pale and moist with perspiration, while his features clearly express his suffering; whereas the respiratory rate is rapid, the pulse is retarded, and the temperature is subnormal. The abdomen is tender throughout. The abdominal muscles are extremely tense, and on palpation they manifest a peculiar quality of rigidity which has been described as board-like. After the pain has persisted for a brief interval, a general condition of prostration, closely resembling shock, supervenes. Unless relieved by massive doses of morphin or by anesthesia and surgical intervention, this clinical picture persists without remission until, after a few hours, the features of diffuse peritonitis appear. Following the supervision of this untoward sequel, death follows in a few days.

**METHOD OF STUDY IN THIS ANALYSIS**

This study was conducted on the clinical records of the cases of gastric and duodenal ulcer, complicated by perforation, which were observed at the Los Angeles County General Hospital between September 9, 1921, and June 30, 1934. During this period, five hundred patients were observed in whom the clinical features were manifest in the acute form. In 98.2 per cent of the patients the diagnosis of perforated peptic ulcer was confirmed either by operation or by autopsy. Included in the study are nine cases, comprising 1.8 per cent of the total number, in which the history and physical findings were so typical as to exclude all reasonable doubt concerning the clinical diagnosis. On the other hand, patients neither

\* From the Department of Surgery of the University of Southern California Medical School.

Read before the General Surgery Section of the California Medical Association at the sixty-fourth annual session, Yosemite National Park, May 13-16, 1935.